State of California – Health and Human Services Agency Department of Health Care Services

PASRR REQUEST FOR RECONSIDERATION

If you wish to discuss the recommendations included in the PASRR Determination, please complete this request form and submit to the Department of Health Care Services.

PASRR Client Identification Number (CID#):	Resident's Name:
Facility Name:	Facility Phone Number:
Facility Address:	Court Appointed Conservator Name and Telephone Number (If applicable):
I am a:	Reason for my request is:
○ Resident ○ Facility Staff ○ Family/Conservator/Other	○ I disagree with the PASRR recommendations. ○ I disagree with the placement. ○ I have another concern.
Please describe your request and the outcome you would like:	
Information of Individual Completing the Form	
Printed Name:	Telephone Number:
Signature:	Date:
Mail to: **Department of Health Care Services** **Clinical Assurance Division (CAD)** **PASRR Section** **P.O. Box 997419 MS 4507** **Sacramento, CA 95899-7419**	Fax to: **(916) 319-0980**

DHCS 3701 (Revised 09/2020)